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ABSTRACT

The report describes a model program designed to develop, implement, and evaluate services to health impaired children in compliance with the mandates of Public Law 94-142 (the Education for All Handicapped Children Act). The first four chapters provide an introduction, statement of the problem, research strategy, and review of the literature. Chapter 5 outlines the eight objectives, including such goals as the development of a screening procedure and placement of all identified children in a least restrictive environment. Chapter 6 describes the procedures in implementing the program. Evaluation of the program is provided in the next two chapters, with applications and conclusions considered in the final two chapters. Samples of forms used in the program and a 225 item bibliography are appended. (PHR)

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ABSTRACT

Developing and Implementing A Model Program for Providing Services to Other Health Impaired Children

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This practicum was designed to develop, implement, and evaluate a model program for providing services to Other Health Impaired Children as mandated by Public Law 94-142. The products included 1) an Other Health Impaired Children Screening Procedure, 2) an Other Health Impaired Children Personnel Training Program, 3) Help Hints for the Management of Other Health Impaired Children (a handbook), and "Medicine Is Not Always Enough" (a slide/tape presentation). The process included screening the student population in two rural school systems with a student enrollment of over 7,500, training special and regular teachers, and serving Other Health Impaired children at the elementary and junior high level. A complete bibliography of more than 225 entries concerning the literature is provided for reference.

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Developing and Implementing A Model Program For Providing Services To Other Health Impaired Children

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DEVELOPING AND IMPLEMENTING A MODEL PROGRAM FOR PROVIDING SERVICES TO OTHER HEALTH IMPAIRED CHILDREN

by

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Our deepest appreciation goes to Dr. Leon E. Curry, M.D., who served as our medical consultant. He opened the doors to educators and provided the guidance necessary for us to succeed. In this endeavor he exemplified the words of Robert Hall concerning a friend:

> A friend should be one in whose understanding and virtue we can equally confide, and whose opinion we can value at once for its justness and sincerity.
>
> He who has the acquisition of a judicious and sympathizing friend, may be said to have doubled his mental resources.

Mary Lee Armstrong
Wendell R. Tanner
Julian A. Williams

CHAPTER ONE

INTRODUCTION

In the United States there has been a growing concern that an equal educational opportunity be provided for all children with particular emphasis on the handicapped. Congressional interests in this area resulted in THE EDUCATION FOR ALL HANDICAPPED CHILDREN ACT OF 1975, commonly called Public Law 94-142.[1] This law proposed that the federal government become increasingly involved in the education of handicapped children by providing excess costs monies directly to state and local educational agencies. These entitlements were accompanied by regulations and guidelines that require concentrated child identification efforts and specific intervention plans. Detailed reports must be filed by local educational agencies that identify handicapped children who were served or unserved, in-school or out-of-school.

Included in the definition of handicapped children issued

[1]Public Law 94-142 (Education for All Handicapped Children Act of 1975), secs. 601-620, 89 Stat. 773 (1975).

by the Bureau of Education for the Handicapped was a new classification entitled Other Health Impaired. Other Health Impaired children are those children who have medically diagnosed physical conditions which are non-communicable, including limited strength, vitality or alertness due to chronic or acute health problems. These conditions include hemophilia, tuberculosis, rheumatic fever, nephritis, asthma, lead poisoning, sickle cell anemia, heart conditions, epilepsy, leukemia and other cancers, and diabetes. The hyperkinetic child would also be placed in this category.[2]

As with most legislation dealing with social problems, subsequent regulations were designed to interpret Public Law 94-142. These guidelines require school systems to provide new services for which existing models are not available such as programs for Other Health Impaired children. Therefore, the local educational agencies must make policies and administrative decisions concerning the provision of an appropriate education for these children within the framework of the school system. This challenge is a monumental task.

[2]Amended Annual Plan for Fiscal Year 1978, Part B, Education for the Handicapped Act (Atlanta, Georgia: Georgia Department of Education, 1977), Appendix B, Number 20.

Traditionally, program development in the area of special education in Georgia has been governed by the Regulations and Procedures issued by the Special Education Division of the Georgia Department of Education.[3] Following the directives of the Bureau of Education for the Handicapped, the Georgia Department of Education has submitted new state regulations for federal approval that include for the first time a category called Other Health Impaired. These criteria have not specified any program requirements. However, monitoring procedures have been established to insure that services mandated by law are being provided.

Most school systems are in a quandary as how to proceed. Some question whether the implementation of these rather complicated procedures to meet the mandates of the law will prove educationally sound. Economic feasibility, even with federal dollars, is another point of interest. The political issue is of concern since the schools have tended to remain apart from traditional medical realms. Therefore, this is a national problem and seems to be of some importance.

[3] Special Education Regulations and Procedures, (Atlanta, Georgia: Georgia Department of Education, 1976).

CHAPTER TWO

STATEMENT OF THE PROBLEM

Coffee County is located in rural southeast Georgia. It has one of the largest school systems in the area. It serves more than 5,600 students with over three hundred professional and two hundred non-professional personnel. The system has nine schools located on eleven campus sites scattered over a large geographic area. During the 1977-78 school year, the Special Education Program in Coffee County provided direct and/or related services to more than nine hundred handicapped and gifted children with twenty-four state allotted and two federally funded instructional units.

Bacon County joins Coffee County to the southeast. It has a smaller school system with a student population of 2,100. The system employs a professional staff of 120 members. The Special Education Program served approximately two hundred handicapped and gifted students with nine state allotted instructional units in the three school facilities. The school plants are located within a one mile radius.

Coffee and Bacon County School Systems had worked cooperatively in sharing personnel and services in the past. Both educational agencies were members of the area Cooperative Educational Services Agency and the Georgia Learning Resources System. During the 1976-77 school year, the systems utilized state allotted special education instructional units to provide services to the mentally retarded and the hyperkinetic children in each county on a shared basis. The services to the hyperkinetic children were a continuation of a federally funded ESEA Title III project, which preceded the mandates of Public Law 94-142. This was an innovative program, the only one of its kind in the State of Georgia and possibly in the nation.

Some children with medical disabilities had been served in the past in each system by a certified hospital/homebound teacher. To qualify for this program, a student must have been projected to be out of school for more than ten consecutive days. Regulations limited these teachers to a caseload of eight students at any one time. Frequently, there were not enough students confined to a hospital or to their homes to warrant this allotment. Therefore, school systems across the State of Georgia have sought alternative ways to serve these children as

well as alternative ways to utilize the hospital/homebound teacher to reach more students. Geographic distances in sparsely populated rural Georgia have prevented efficient multi-system sharing in this area of special education.

Many students who were classified as Other Health Impaired did not qualify for the hospital/homebound program because they did not have extended absences. The specific number of these children must be based on estimations. Medical personnel have stated that approximately seventeen percent of the child population below the age of fifteen is developmentally delayed.[1] This number includes the estimated twelve percent of the student population classified as handicapped by the Bureau of Education for the Handicapped.[2] Therefore, it has been quite difficult to project the number of children who need special services because of medically diagnosed conditions which affect their

[1]Curry, Leon E., M.D., "Medical Problems in School Children." A presentation to the Douglas Chapter of the Association for Retarded Citizens, April 1977.

[2]Special Education Regulations and Procedures, 1976.

ability to learn. Extensive screening and identification procedures will need to be conducted in the near future to provide this information to the educators who are planning programs and delivery models. However, for the purposes of this practicum, a five percent incidence for the prevalence of Other Health Impaired children in the student population (age 5-18) was established.

With the exception of the hyperkinetic child for whom services had been provided in Bacon and Coffee Counties, the children with other health impairments had been placed in the regular classroom or special education program depending on mental abilities and identified learning disabilities. Health records may or may not have specified physical conditons that existed. Many times classroom teachers were not aware that a child had a chronic illness. Educators had had no training in the effects of a particular medical condition on a child's ability to perform. In addition, no materials have been available concerning program adaptations with the possible exception of physical education.

According to the national incidence figures concerning epilepsy, Coffee County would be expected to have as many

as one hundred epileptic children in the system. Only twenty-five had been brought to the attention of the school system. A similar situation existed in Bacon County. Disparities between incidence figures and the number of identified cases were evident in all of the conditions listed as other health impairments.

An informal survey conducted by the participants of ten regular classroom teachers revealed that ninety percent believed that hyperkinetic children children could control their behavior if they wanted to and one hundred percent believed that the condition was primarily due to the lack of discipline. In the survey the use of medicine for any condition other than major health problems such as cancer and diabetes was questioned by eighty percent of those interviewed. Of this group of teachers, ninety percent of the respondents could make allowances for the child with a kidney condition to go to the restroom more frequently than his peers, but only twenty percent considered having allergies as being of possible educational significance.

Based on these data, there seemed to be a need for a specific program for Other Health Impaired children. For the purposes of this practicum, the participants

selected one school in each system as pilot sites. Central Elementary School in Coffee County with a student population of 710 and Bacon County Junior High with a student population of 509 were chosen.

An analysis of the school records revealed that Central Elementary School had identified five hyperkinetic children and four epileptic children. Other conditions considered as other health impairments had not been noted. Since the medical profession has estimated that five percent of the student population have significant health problems, thirty-five remained unidentified. None of the forty-five classroom teachers had had training in providing educational adaptations for these children should they be identified.

Student record analysis at Bacon County Junior High showed that the same need existed. According to incidence figures, as many as twenty-five children would be expected to have medical diseases or syndromes that would require educational provisions. Only six hyperkinetic and three epileptic students had been identified. The twenty-four classroom teachers had been trained in the educational problems of the hyperkinetic child, but had had no instruction concerning the problems of children with other chronic or acute childhood diseases or syndromes.

The extent to which Other Health Impaired children are handicapped academically by their physical condition is not known. Theoretically, the physical condition limits strength, vitality and/or alertness to the point that learning is affected. Therefore, these children require direct and/or related services in order to reach their full potential in the educational system.

Unlike some categories of handicapped children such as the mentally retarded or learning disabled, there are no specific intellectual ranges by which to establish adequate academic expectations for the Other Health Impaired child. His educational potential may be hampered solely by the fact that his heart condition causes him to be absent from school frequently. Or the child with epilepsy may also be mentally retarded and need a curriculum designed for this disability area. According to Wender, probably eighty percent of the learning disabled children are hyperkinetic to some degree.[3] Therefore, it is extremely important that programs designed for Other Health Impaired children establish measurable objectives for individual children based on diagnostic data with appropriate evaluation delineated.

[3]Paul Wender, "The Minimal Brain Dysfunction Syndrome in Children," Journal of Nervous and Mental Disorders 155 (1972): 55-71.

A random sample of Other Health Impaired children who had already been identified by the participants was selected. The Slosson Intelligence Test and Wide Range Achievement Test were administered to these children (N=10). The data presented in Table I illustrates the results of this preliminary screening program.

TABLE I

OTHER HEALTH IMPAIRED CHILDREN
PRELIMINARY SCREENING

STUDENT	HEALTH IMPAIR	IQ	GRADE	READING	ARITHMETIC
A	Hyper	112	6	5.1	4.1
B	Epil	92	7	4.9	4.5
C	Hyper	101	7	6.5	3.4
D	Diabe	115	6	4.2	2.4
E	Epil	89	3	1.1	2.4
F	Hypo	95	8	6.4	6.9
G	Epil	70	5	2.1	1.8
H	Hyper	136	7	6.2	6.6
I	Asthma	103	5	4.4	4.7
J	Sickle	89	6	2.1	2.0

Based on the initial inquiry, it seemed that the Other Health Impaired children in this sample were all functioning below grade expectations. Regardless of the physical

disability and regardless of the measured intellectual functioning, the students were achieving six months to three years below grade expectation in reading and/or arithmetic.

The realization that test data have been unreliable in the best testing situations is further complicated by the fact that Other Health Impaired children are chronically or acutely ill. Some of these chidren have never had problems in school until their medical conditions occurred. For example, a child may perform well academically until he develops juvenile diabetes. His grades plunge and there is a period where support is needed until the physical, emotional and mental adjustments can be made. Later, the support may not be as necessary or even required.

Asthmatic children frequently outgrow their health problem as they mature. For this particular group, support is needed during the years when the condition is active. Later, it can be withdrawn. However, for the child with sickle cell anemia, educational support may be required throughout the child's years in school. In fact, he must be taught that he will have to depend more upon his mental abilities than upon physical abilities in his vocation or life's work.

After lengthy discussions of the problems related to the development of services in this area as mandated by Public Law 94-142, the participants decided that it would be more advisable to be a part of the development of procedures than to await policy dictation. This decision was based primarily on the fact that a need for services to Other Health Impaired children did indeed exist. Another factor was that the school systems had worked together to provide services to the hyperkinetic child, which had been quite effective. Since the embryonic efforts to serve the hyperkinetic child had been educationally sound, economically feasible, politically popular and legally sound, the participants decided that the systems could work together to develop a model that could serve Other Health Impaired children.

The specific problems that evolved were how the educational programs of children who had medically diagnosed, chronic or acute physical conditions that limit strength, vitality or alertness should be adapted? What specific adaptations should be made? To what extent do these conditions affect learning? What should be the school's role in monitoring the treatment of Other Health Impaired children?

CHAPTER THREE

RESEARCH TO DEVELOP A STRATEGY

Several methods of establishing a model program for Other Health Impaired children were considered. The first possible solution was to expand the services of the hospital/homebound program by employing more teachers certified in this field. Under Georgia Department of Education guidelines, each instructional unit utilized in this manner could carry a caseload of eight children at one time. This idea was discarded for two reasons. The federal and state regulations require that a handicapped child be educated in the least restrictive environment, which is with his peers in the regular classroom whenever possible. Serving the child in his home or in the hospital would not be satisfactory. Secondly, the cost of employing enough teachers to serve more than sixty children in the two pilot schools on a 1:8 ratio would be in excess of $80,000.

One answer to the problem involved the use of consultants to provide workshops for special education teachers and

school psychologists. However, since the majority of Other Health Impaired children would probably be in the regular classroom, this concept was ruled out.

The third strategy consisted of planning and conducting staff development activities for regular classroom teachers to be held on a yearly basis. This alternative approach would serve to make teachers more cognizant of the problem but would not insure the implementation of program adjustments.

The development of a handbook for teachers concerning the adaptive environment needed by children with certain medically diagnosed diseases and syndromes was proposed. However, this solution would not serve to meet the regulations pertaining to services for exceptional children and no provisions would be made to monitor program development.

Since services to Other Health Impaired children provide a new concept in education, demonstration projects and commercially prepared materials were not readily available. However, the participants were aware of a previously developed research and demonstration project for the hyperkinetic child, one area of Other Health

Impaired that had been adopted by their school systems. This program would serve as a basis for the proposed model.

Project HELP (Hyperkinesis: an Educational Learning Problem) was a federally funded ESEA Title III project that was conducted by the Waycross Area Program for Exceptional Children to which both of the school systems belonged. This program was designed to identify, screen, refer, and monitor treatment of hyperkinetic children through student observation, evaluation and teacher conferences. The second component of the program consisted of teacher and parent training in the characteristic behaviors of children with the syndrome that required adaptive management and teaching techniques. The third facet of the effort was community awareness.[1]

The participants decided to adapt Project HELP to be the model for the delivery of services to Other Health Impaired children. After the model was developed, implemented and evaluated, it could be institutionalized and

[1] Mary Lee Armstrong , Project HELP(Hyperkinesis: an Educational Learning Problem) (Waycross, Georgia: Waycross Area Program for Exceptional Children, 1974).

continued in each system by the hospital/homebound teachers or other staff under the direction of the Coordinators of Special Education. Since the materials would be available, the training of new teachers could be conducted on a yearly basis.

CHAPTER FOUR

REVIEW OF THE LITERATURE

There were three purposes to be served by a review of the literature related to the development and implementation of programs for Other Health Impaired children. A search of the Educational Resources Information Center (ERIC) entries, Current Journals In Education (CJIE), and Index Medicus (IM), was needed in order to determine whether there were existing delivery models that could be adopted to meet the particular needs that had been identified. Also, it was necessary to compile a listing of the materials that could be secured by parents or teachers to better understand and cope with specific conditions and syndromes of the Other Health Impaired child. Lastly, it was essential to secure valid information concerning the educational implications of the various diseases and syndromes in order to insure that materials developed were based upon fact, and not speculation or fantasy.

In the formative stages of program development, a review of the literature was made to determine appropriate delivery models. It was found that programs for Other Health Impaired children were found in the literature in a more narrow scope than was planned by the participants. School

based programs seemed to be restricted to one or two of the conditions selected to be served as Other Health Impaired. One school would provide services for epileptic students, while another served children suffering from allergies. Others initiated services only to health impaired children with other learning problems such as mental retardation or hearing impairments.[1]

Separate educational facilities have been established in some instances to serve young people with medical disabilities. Schools for children with leukemia or severe epilepsy have been justified on the grounds that the child is not able to physically cope with the rigors of normal learning institutions. Even the founders of these separate enterprises admit that for children who can attend public schools, it is best to allow them to do so. The

[1]Harry Best, Public Provision for Epileptics in the United States, (New Jersey: Tyco Shipping Service, Inc., 1969): 34-42; Meyer B. Marks, "Recognition of the Allergic Child at School," Journal of School Health 44 (May 1974): 277-84; June C. Foster and Peggy Kapisovsky, Accommodating Students Who Have Physical Disabilities, (Cambridge, Mass.: Technical Education Research Centers, Inc., 1975), 116-23; and Raymond M. Peterson and James O. Cleveland, Medical Problems in the Classroom: An Educator's Guide, (Springfield, Ill.: Charles C. Thomas, 1975), 27-45.

association with healthy children is a benefit in adjusting to the handicap.[2]

Hospital based programs as well as home based programs for the health impaired have proved valid only for children who are so ill that there is no other alternative. In a recent training manual for nursing students, it was stated that in most circumstances students should be allowed to attend a school with well children in order to help reduce the feeling of frustration that accompanies chronic illnesses.[3]

It was found that delivery systems ranged from self-contained classes in some programs to a facilitator concept in others. A facilitator works as liaisonbetween the classroom teacher and the doctor or parents. Arrangements are

[2]Lynn S. Baker, You and Leukemia -- A Day at a Time, (Rochaster, Minn.: Mayo Comprehensive Cancer Center, 1976): 45-51; Ann Hackney and David Taylor, "Epilepsy and the Ordinary School," Special Education Forward Trends 3 (March 1976): 12-15; Florence Dakin and Ella M. Thompson, Simplified Nursing, (Philadelphia, Pa.: J. B. Lippincott Company, 1973): 221-249.

[3]Lester Tarnopol, Learning Disabilities: Introduction to Educational and Medical Management, (Springfield, Ill,: Charles C. Thomas, 1974): 61-89; Ruth V. Bien, Practical Nursing Procedures, (Albany, New York: 1974): 67-72.

made for the diabetic child to receive a proper diet by the facilitator. Physical education will be adapted for the needs of the individual through the facilitator working with the instructor. Medication may even be monitored with the advice and consent of parents and doctor. The facilitator may even work with the teacher in providing the educational activities needed. However, the child is instructed in the regular school program as much as is possible, with only the watch-care of the facilitator.[4]

The second phase of the review of the literature was to secure materials from national and state health agencies that would aid in developing training devices and instructional tools. Fifty agencies were mailed requests for materials. Of these, forty-three responded. Approximately three hundred separate pieces of information were received in the form of pamphlets, brochures, or monographs.

[4]Directory of Resources for the Developmentally Disabled, (Tallahassee, Fla.: Florida Developmental Disabilities Planning and Advisory Council, 1974): 196-211; Arthur S. Daniels and Evelyn A. Davies, Adapted Physical Education for Exceptional Students, (Bethesda, Md.: ERIC Reproduction Service, ED 015 594, 1965): 24; R. D. Freeman, "The Drug Treatment of Learning Disorders: Continuing Confusion,: Journal of Pediatrics 1 (July 1972): 112-5.

The bibliography contains a listing of these materials that relate to the sixteen conditions and syndromes selected.

Many of these responses contained materials that grouped two or more conditions under one classification. For example, leukemia, hemophilia, and sickle cell anemia might be consolidated under the heading Blood Disorders. Lung conditions might include allergies, tuberculosis, and rheumatic fever. The bibliography is, therefore, organized in this way.

The final component of the research of related literature was conducted in order to develop a knowledge of the symptoms, educational implications, and adaptations that might be needed in an Other Health Impaired Program. The information gleaned from this search was used in the development of the manual, Help Hints for the Management of Other Health Impaired Children. It was also a necessary part of the training program and the monitoring procedures for the project.

Graef, Stern, and Scott point out that children may have the same illnesses as do adults. However there

are many differences in the effects of treatment. The greatest differences are in the effects of the condition on the patient. In the instance of heart conditions, persons past middle age do not find it as difficult to lead a quiet, sedentary existence. A child, however, must relinquish the very things that are most natural to his age--running, jumping, sports. The older person has had his education and many experiences; the child with sickle cell anemia is just beginning his. The epileptic resents being different from his peers more than most adults, who have learned to take such things in stride.[5]

The value of cooperation between school, home and hospital has been emphasized by Dykes, King, Weber, and Hinesley. Medical personnel are of primary importance in the diagnosis and treatment of medical disabilities. No illness can be remediated as readily in the absence of medical treatment as it can be if knowlegeable examinations, diagnosis, and treatment are supervised with care.

[5]John W. Graef and Thomas E. Cone, Manual of Pediatric Therapeutics, (Boston, Mass.: Little, Brown and Company, 1974): 1-10; Donald Scott, About Epilepsy, (New York, N. Y.: International Universities Press, Inc., 1969): 113-23; Sheldon B. Stern, Educational Program for Pediatric Inpatients at the Geisinger Medical Center, (Bethseda, Md.: ERIC Reproduction Services, ED 008 082, April 1975): 25-30.

The manner by which parents react to the condition is also reported to be critical. However, medicine is not always enough, and neither are supportive parents always adequate to provide for the total needs of the child. Only when medical personnel, parents and schools join forces can all of the needs of the sick child be met.[6]

In a school based program for Other Health Impaired students, many adaptations and provisions must be made. Livinston and Curry present a strong case for the need to establish a medicinal monitoring procedure. Such a procedure would allow medication prescribed by the doctor and needed by the student during school hours to be kept and dispensed by some one individual within the school. Abbott Laboratories, a pharmaceutical company, stresses clearly the fact that much of the medication prescribed for conditions such as epilepsy and hyperkinesis may require drugs that could lead to abuse by other students, if the

[6]Mary Kay Dykes, "Competency Needs of Special Educators of Crippled and Other Health-Impaired Children," Journal of Special Education 9 (Winter 1975): 1-8: John D. King, Counseling With Parents of Exceptional Children, (Austin, Texas: University of Texas, 1973): 1-46; Elmer W. Weber, Health and the School Child, (Springfield, Ill.: Charles C. Thomas, 1964): 45-67; and Howard J. Hinesley, Primary Handicaps of Students in Programs for the Physically Handicapped, (Tallahassee, Florida: Florida State Department of Education, 1973): 1-19.

medication were allowed to be carried around the school by the child.[7]

The need for adaptations in the physical education program is recognized by the Bureau of Outdoor Recreation, as well as Stamford, Geddes, and Arnheim. Some conditions may require no participation in physical activities. Limited activities may be permissible in other instances. Sometimes certain diseases and syndromes need a particular type and amount of exercise for faster recuperation. Sickle cell anemia might be complicated by the breath holding necessary in underwater swimming. This may be the very activity to strengthen the lungs of the asthmatic. School programs in adaptive physical education are invaluable

[7]Samuel Livingston, "Diagnosis and Treatment of Childhood Myoclonic Seizures; " Journal of Pediatrics 53 (April 1974): 530-33; Léon E. Curry and Mary Lee Armstrong, "Management of MBD/Hyperkinesis by the Family Physician," A paper presented at the Continuing Education for Family Physicians, Funegirola, Spain, 3 November 1975; Clinicans Discuss MBD Medication from the Parent's and Child's Point of View, (Chicago, Ill.: Professional Relations Department of Abbott Laboratories, 1978).

in providing for the Other Health Impaired.[8]

Bien, McKigney and representatives of the American Diabetics Association have identified a most significant resource in the school setting that is basically untapped. This resource is the food services program. For the diabetic, special diets are usually needed. Orange juice or peanut butter should be kept in ready access for the child who needs a boost in blood sugar. Of course, the child with an ulcer and the child who is allergic to certain foods and substances must have provisions made. Even a normal diet that is nutritious and helps strengthen the body is invaluable.[9]

[8]"Outdoor Recreation Planning for the Handicapped," (Washington, D. C.: Bureau of Outdoor Recreation, 1967): 1-49; Bryant A. Stanford, "Cardiovascular Endurance Training for Blind Persons," New-Outlook for the Blind 69 (September 1975): 308-11; Delores M. Geddes and Wanda L. Burnette, Physical Education and Recreation for Impaired Disabled and Handicapped Individuals...Past, Present, and Future, (Washington, D. C.: American Alliance for Health, Physical Education, and Recreation, 1975): 133-38; Daniel D. Arnheim, and others, Principles and Methods of Adapted Physical Education, (St. Louis, Mo.: C. V. Mosby Company, 1973): 325-40.

[9]Ruth V. Bien, Nutrition and Meal Preparation for the Practical Nurse, (Albany, N. Y.: Delmar Publichers, Inc., 1966): 13-5; Exchange List for Meal Planning: A Helpful Guide for a Healthier You, (New York, N. Y.: American Diabetes Association, Inc., 1976); U.S. Department of Health, Education, and Welfare, Feeding the Sick Child, (Bethesda, Md.: National Institutes of Health, 1976; John I. Mckigney, Nutrient Requirements in Adolescence, (Bethesda, Md.: National Institute of Health, 1976).

Even though physical education, lunchroom programs, and medication are important school adaptations that are necessary for the young person with a medical problem that affects his learning, there is one other factor that is just as valuable. Many feel that the most valuable service that a school may render a child with a health impairment is through modification in classroom procedures. Providing seating in the best lighted part of the classroom for children with visual problems as a result of conditions that may affect sight. Preferential seating must be provided for those who have hearing problems as a result of illnesses. Individualized instruction must be provided for children who have limited learning potential as a result of a medical problem, whether the potential is limited temporarily or permanently.[10]

An important role of the school in serving health impaired children is that of monitoring, and this is closely followed by the reporting function. The child is in

[10]J. P. McGovern, and others, Allergy As A School Health Problem, (Springfield, Ill.: Charles C. Thomas, 1975); How to Cope With Diabetes, (New York, N.Y.: Juvenile Diabetes Foundation, 1977); Epilepsy School Alert--What Teachers, Nurses and Students Should Know About This Common Disorder, (Washington, D.C.: Epilepsy Foundation of America, 1974); Jerrold S. Greenberg, "Hyperkinesis and the Schools," Journal of School Health 46 (February 1976):91-7.

school approximately four to six hours a day. During this time the school should be aware of the potential danger signs of recurrence or relapse of the condition. Teachers need to be in regular contact with parents and physicians to report the child's reaction to routine work days. School time may be the nearest equivalent to a work day that the child will face. It is helpful to the doctor in prescribing treatment and medication to know how the patient reacts in this setting.[11]

It cannot be implied that no problem exists in efforts to mainstream health impaired children. Clouser states that too often adults try to rid themselves of the unpleasantness of being in contact with children with medical problems, especially if the case is terminal, crippling, or produces bizzare or different behavior patterns. According to Jones, this may be the reason that epileptic and hyperkinetic behavior repulses many.

[11]Michael Rutter, and others, Education, Health and Behavior, (New York, N.Y.: John Wiley and Sons, 1970): 122-5; To Every Man His Chance: A Program Guide, (Washington, D.C.: President's Committee on Employment of the Handicapped, 1968): 1-39; Exceptional Children Conference Papers: Pre and Inservice Teacher Preparation, (Arlington, Va.: Council for Exceptional Children, 1971): 1-34.

This may be the reason that a child with terminal cancer is relegated to the hospital or homebound program for instruction.[12]

Kaplan states that adults excuse the rejection impulse by claiming to be protecting the normal child. One cannot afford to upset the normal child with the presence of such traumas. However, a recent study reported by Dickinson indicates that adults are more disturbed by the presence of children who are ill than are the youthful peers of the sick youth. Therefore, Knotts concludes that health impaired children will provide no major traumas in the regular school program.[13]

[12]Kenia Clouser, "The Psychological Effects of Hospitalization for the Child and Family--Implications for the School System," A paper presented at the annual international convention of the Council for Exceptional Children, Chicago, Ill.,(April 1976); R. S. Jones and J. B. Owen-Thomas, Care of the Critically Ill Child, (Baltimore, Md.: Williams and Wilkins Company, 1971):25-38.

[13]David Kaplan, and others, "School Management of the Seriously Ill Child," Journal of School Health 44 (May 1974): 250-44; William B. Dickinson, Editorial Research Reports on Health Topics, (Washington, D.C.: Congressional Quarterly Inc., 1976): 64-8; Glenn R. Knotts, ed., "1975 Schering Symposium: Chronically Ill and Handicapped Children," Journal of School Health 46 (June 1976): 25-38.

It would seem to be evident, then, that a teacher can have a classroom setting relatively free from trauma with several health impaired students in the class. In order to accomplish this, certain arrangements and precautions must be taken. The teacher must be aware of the problems that exist. Is the problem hyperkinesis or epilepsy or sickle cell anemia? What are the first aid measures needed to cope with the condition should a crisis arise? Expected behavior and learning patterns indicative of the disease or syndrome should be known and anticipated. In addition, the teacher must provide instruction that meets the child's individual needs, including rest periods, time for medication and the remission-recurrence cycles that interfere with constant learning rates.[14]

Conner warns that the school must be careful in labeling a child as Other Health Impaired. Placement in the program should begin with a comprehensive screening

[14]Bill R. Gearhart and Mel W. Weishahn, The Handicapped Child in the Regular Classroom, (St.Louis, Mo.: C. V. Mosby Co., 1976): 111-15; Ronald S. Illingworth, The Child at School: A Pediatrician's Manual for Teachers, (New York, N.Y.: John Wiley and Sons, 1974): 23-7; Edward R. Klebe, Key Facts on the Handicapped, (Washington, D.C.: Congressional Research Service, 1975): 30-2.

process including medical diagnosis. It should proceed to evaluation of the academic potential and achievement. An individual program of experiences should be planned in order to meet the educational, physical, and emotional needs of the students. The process should not end until the child has been released by the physician or until the school has the doctor's statement that services are no longer needed.[15]

[15]Frances P. Connors, ed., Leadership Preparation Educators of Crippled and Other Health Impaired- Multiply Handicapped Populations, (New York, N. Y.: Columbia University, 1971): 11-15.

CHAPTER FIVE

OBJECTIVES

In order to conduct this practicum, the following objectives were established:

1. As a result of this practicum, a model program for providing services to Other Health Impaired children (N=60+) will be developed, implemented and evaluated at Bacon County Junior High and Central Elementary School by 30 June 1978 as evidenced by the Child Find Report[1]

2. As a result of this practicum, a screening procedure will be developed and administered at Bacon County Junior High and Central Elementary School by 30 June 1978 as evidenced by the appropriate forms and procedural guidelines

3. As a result of this practicum, Other Health

[1]The Child Find Report is a semiannual report made by local educational agencies to federal auditors certifying the number of handicapped children identified, evaluated, placed, served or unserved. This is an unduplicated count and some adjustment will be required for handicapped children who have primary disabilities other than Other Health Impairment.

Impaired children (N=60^{+}) at Bacon County Junior High and Central Elementary School will be identified by 30 June 1978 as evidenced by the Child Find Report

4. As a result of this practicum, all children identified as Other Health Impaired will be placed in the least restrictive environment according to due process procedures and will have Individual Education Plans within thirty days of placement as evidenced by completed due process and Individual Education forms in the student folders

5. As a result of this practicum, all teachers at Bacon County Junior High and Central Elementary School (N=65) will have staff development training related to Other Health Impaired children by 30 June 1978 as evidenced by agendas and role of participants

6. As a result of this practicum, all parents of Other Health Impaired children (N=60^{+}) will be involved in the planning of their child's Individual Education Plan as evidenced by their signatures on the child's Individual Education Plan written within thirty days of placement

7. As a result of this practicum, 90% of the Other Health Impaired children identified and placed will be receiving the educational and related services mandated by their Individual Educational Plans by 30 June 1978 as evidenced by student records, the Georgia Superintendent's Report and the Child Find Report[2]

8. As a result of this practicum, all of the Other Health Impaired children (N=60^{+}) will be achieving academically as well as or better than they achieved prior to the establishment of the program by 30 June 1978 as evidenced by scores on academic tests

[2]The reason for the 90% criterion is the fact that some of the related services needed by the children might not be available due to limited funds and personnel.

CHAPTER SIX

PROCEDURES

The first step in initiating the practicum was to obtain the permissions and approvals necessary to conduct the project. Written approval and support was secured from the superintendents and principals who would be involved. Willingness to participate in the development and evaluation of the materials was received from the observers. Agreements to work with the program were also secured from the hospital/homebound teachers who would function as a primary resource in the delivery of services. At this point it was possible to proceed with the practicum assured that no one could arbitrarily put an end to the effort before it was finished. The remaining procedures that were utilized in the development, implementation and evaluation of the practicum can be divided into two measures: product and process.

Product

Before the implementation of a model program to provide direct and/or related services to Other Health Impaired

children could be adequately initiated, four products had to be developed and evaluated. These consisted of 1) a screening procedure, 2) a management guide for teachers and parents, 3) a personnel training program and 4) an audio-visual training and dissemination packet.

A review of the literature was made to determine the background information needed and to secure materials for the development of the products. Since new federal and state guidelines were being issued periodically, it was necessary to be aware of changes that might need to be included in the final product. The 26 August 1977 issue of the Federal Register was carefully considered for this purpose.

A number of public and private resources was contacted for information and materials. Local, state and federal Departments of Public Health were approached. These agencies provided booklets and pamphlets. The local organizations volunteered to provide assistance with screening and medical evaluation of Other Health Impaired children whose parents did not have medical resources available.

Consultants in the Bureau of Education for the Handicapped

were approached for interviews and conferences on the matter. A visit was also made to the National Institute of Mental Health and National Institute of Health in Bethesda, Maryland during the summer of 1977. These agencies provided suggestions for materials and publications for utilization. They were unable, however, to direct the participants to any similar projects or other viable delivery models for services to Other Health Impaired children.

Fifty national and state health agencies such as the American Kidney Association were contacted by letter for suggestions and management techniques. The response was very favorable with return acknowledgments from over forty organizations.

State, area and local special education and medical consultants were contacted. Staff personnel from the Special Education Division of the Georgia Department of Education were interviewed for ideas, suggestions and comments. This group was able to keep the latest federal and state regulation changes available. The division was very supportive of the concept and quite interested in assisting with the dissemination. Area personnel trained in special education from the Cooperative Education Services Agency,

the Georgia Learning Resources System and Valdosta State College were contacted for recommendations and external evaluation.

Twenty-five area and local physicians were approached. They were most receptive and willing to cooperate. In addition, the Health Committee Chairman of the area medical society responded pledging the support of the medical personnel to the project.

Dr. Leon E. Curry, a Family Physician and Director of the Developmental Analysis Center in Metter, Georgia, agreed to serve as the medical consultant. He worked closely with the participants in each step of the development of the training materials and wrote the Foreword for Help Hints for the Management of Other Health Impaired Children. He also traveled over a hundred miles to assist with the production of the slide presentation, "Medicine Is Not Always Enough".

After gathering and reviewing the material and guidelines pertaining to various childhood medical conditions, the participants began to develop the practicum products (Screening Program for Other Health Impaired Children, Help Hints for the Management of Other Health Impaired

Children, "Medicine Is Not Always Enough" and the Other Health Impaired Children Personnel Training Program).

1. Screening Program for Other Health Impaired Children

The first step in designing a screening program for Other Health Impaired children was to determine specifically which medical conditions would be considered. This was a necessary step because the federally mandated regulations give an open-ended definition with the concept of medically diagnosed physical conditions that limit strength, vitality, or alertness such as . . .[1]

The participants contacted Dr. Curry, the medical consultant, for assistance. Together they established a list of sixteen physical conditions that affect strength, vitality, and/or alertness and the results of which might handicap the child in the school setting or in the learning environment. These conditions were: allergies, arthritis, asthma, epilepsy, heart condition,

[1]Public Law 94-142 (Education for All Handicapped Children Act of 1975).

hemophilia, hyperkinesis, hypertension, hypoglycemia, juvenile diabetes, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and tuberculosis. Provisions were made to include other handicapping medical conditions as the need arises. However, it was obvious that certain arbitrary limits had to be initially established.

After the decision was made as to which medical conditions would be considered for the purposes of the practicum, a checklist was designed.[2] It was submitted to the internal observers for comments and suggestions. It was then sent to the medical advisor and other external observers for critique. As a result, two terms were modified.

The utilization of internal and external observers was considered to be very important. The internal observers consisted of a principal, a school nurse and a school counselor. The external observers consisted of the three individuals who had agreed to serve as the practicum observers.

[2]The checklist is appended on page 88.

These consultants were trained in special and/or medical education and had had experience with federal guidelines. Their comments were extremely valuable in keeping the products practical since each one works in the general area and is familiar with the concept. They helped to establish adequate expectations and assisted in keeping the products from becoming too academic and technical. It was also required to document medical information since the participants had had little training in this area and wanted the project to have credibility.

The checklist was then reproduced and submitted to the parents and/or guardians of each child (N=1200+) enrolled in Central Elementary School and Bacon County Junior High. The classroom teachers were asked to issue and collect the forms for the Other Health Impaired teacher.

Additional datawere gathered by the Other Health Impaired teachers. They worked with the principals and school counselors in examining the school health records. However, since school health records are often incomplete, it was decided that the checklist was an important procedure to follow.

Another aspect of the screening and referral procedure was conducted through the use of a dissemination and referral brochure.[3] The "Find and Help Other Health Impaired Children" pamphlet was designed by the participants and reproduced by a local printer. Two thousand of these brochures were then distributed to physicians, health agencies, community organizations and others were placed in public gathering places such as the supermarkets and drug stores.

Procedural due process safeguards are mandated by Public Law 94-142 for all children considered for special services. From the time a school begins to consider a child for referral to the time that a child begins to receive special services, the parents and/or guardians must be informed and must provide consent. Specific guidelines and forms for these procedures were developed and printed in the Procedural Due Process Handbook[4] for Coffee County which was later

[3]A "Find and Help Other Health Impaired Children" brochure is appended on page 89.

[4]Mary Armstrong, Procedural Due Process Handbook, (Waycross, Georgia: Nova Introductory Practicum, 1977): pp. 50-62. For a copy of this manual contact: Mary Lee Armstrong, POB 959, Douglas, Georgia.

adopted and adapted for the Bacon County School System. These regulations were included in the Annual Program Plan FY 77 of each system and submitted to the Georgia Department of Education. After approval was obtained from this agency, the local boards of education officially adopted the plans as the board policy on special education for the fiscal year. These procedures were followed for Other Health Impaired children.

Release forms were also developed to provide a system of obtaining medical information from physicians and to release educational information to the child's physician. In addition, medical feedback forms were developed to facilitate the communication process.[5]

The specific steps of the screening procedure were:

a. Inform parents or guardians of intent to refer
b. Complete referral
c. Obtain parental consent for evaluation

[5]The forms are appended on pages 90-92.

d. Conduct vision and hearing screening

e. Conduct observational and diagnostic evaluations

f. Obtain medical information from physician(s)

g. Obtain additional evaluative information (psychological, educational and/or medical) as needed

h. Contact parents for placement committee meeting

i. Schedule placement committee meeting with parents, regular class teacher, special teachers, principal or another representative of the school

j. Secure from the placement committee a decision as to whether the child's medically diagnosed physical condition is an educational handicap and warrants direct and/or related special education services. This decision is made on the basis of the information obtained in the screening process

k. Develop an Individual Education Plan[6] with long-term goals and short term objectives during the placement meeting with each

[6]Sample Individual Education Plans for Other Health Impaired children are included on pages 93-95.

member participating. The strengths and weaknesses of the child are listed. Criteria for mastery of the objectives are established. An evaluation procedure including a time-line is scheduled. The anticipated duration of services and the annual review date is listed. Specific related services such as a special diet, administration of medication according to the physician's prescription, and monitoring behavioral change are also written into the plan. The Individual Education Plan is written for the individual child based on specific diagnostic and evaluative data with predetermined criteria to evaluate the appropriateness of the plan

l. Obtain written permission for placement in the Other Health Impaired children's program and a signature verifying the parent's agreement with the Individual Education Plan

m. Initiate services

n. Verify placement with the Coordinator of Special Education to be included on state attendance forms

o. Reevaluate placement at least annually by officially designated placement committee

2. Help Hints for the Management of Other Health Impaired Children[7]

The development of a practical handbook for use by classroom teachers and parents in the management of Other Health Impaired children was considered to be one of the most vital parts of the project. Since more than ninety percent of the children who suffer from health problems are placed in regular classes with their peers, it seemed extremely important that the teachers of these children have a working knowledge of the problem.

A survey was made of the materials that had been gathered on each condition. After an overview had been made, a decision concerning the organization and

[7]A copy of Help Hints for the Management of Other Health Impaired Children is provided under separate cover. This manual may be obtained for the cost of reproduction from Mary Lee Armstrong, Coffee County School System, P. O. Box 959, Douglas, Georgia 31533.

amount of matter to be included had to be made. Taking into account the fact that teachers are very busy, an effort was made to devise a simple, usable reference book with easy access to pertinent information. The format that was selected for use with each medical condition included:

a. Condition
b. Definition
c. Symptoms
d. Incidence
e. Age of Onset
f. Prognosis
g. Treatment
h. Educational Significance
i. Educational Adaptations
    1) Physical adaptations
        a) Classroom environment
        b) Physical education
        c) Diet
    2) Academic adaptations
    3) Classroom management
j. Feedback Alerts

The handbook also included an introduction with the rationale for the program, a short guide to facilitate utilization of the manual and a section on public and

private agencies and organizations from whom free and inexpensive materials and additional information may be obtained. After the first draft of the handbook was written, it was submitted to the medical consultant for critique. Using his suggestions and recommendations, the handbook was rewritten. It was then submitted to the internal and external observers for evaluation.

Dr. Curry, the medical consultant, agreed to write the Foreword. The Media Department of South Georgia College was contracted to design and print the cover. The spiral binding was selected to facilitate utilization and to preserve economy since the participants and staff could assemble the final product.

Transparencies were made from the originals and stored for use in the personnel training components of the project. The equipment was available and inexpensive to employ. These visual aids were stored for use during the practicum year and in the institutionalization of the effort in the future.

Help Hints For The Management of Other Health Impaired Children was designed as an initial reference for teachers and parents. As other projects are reported and papers are written concerning the various handicapping conditions, more information and other conditions can be added.

3. "Medicine Is Not Always Enough"[8]

Since the concept of the Other Health Impaired Child as a classification of handicapped children was so new, there were no media productions available for training and dissemination. The participants decided to write and produce a slide/tape presentation to serve this purpose. It was entitled "Medicine Is Not Always Enough" to convey the idea that the school also has a role in caring for the sick child.

This was possibly the most time-consuming and yet most rewarding component of the group practicum.

[8]A copy of the slide/tape presentation is submitted to be placed on file at Nova University. For more information about this media production, contact: Mary Armstrong, P.O.Box 959, Coffee County Schools, Douglas, Georgia 31533.

A tentative script with visual and audio descriptors was written. After consulting with the internal and external observers, the script was revised several times before each of the participants agreed that the presentation conveyed the concept of the project.

Preliminary production steps included extensive planning and organization. Parental permission and releases had to be obtained for each child model after the decision was made concerning which particular child to use for a condition. Schedules had to be devised and coordinated since the participants worked in different counties. School scheduling problems also had to be anticipated and handled.

Production assistance had to be arranged. The Media Department of South Georgia College contracted to draw and reproduce the graphic illustrations while the spouse of one of the Nova participants agreed to make the photographs. The Bacon County Hospital Authority granted permission for an out-of-town physician to use the facility to add authenticity to the productions. This saved transporting twenty children over two hundred miles for a dozen photographs.

After the slides were made, the participants had to select the most appropriate picture for each visual cue on the script and set up the production of the audio tape. WULF, a local radio station in Bacon County, worked with the participants to provide the recording facility and musical background for one of the participants to read the script. Later, the Media Department at South Georgia College assisted with putting the synchronization on the tape and making duplicates. In addition, duplicate slides were obtained.

The internal and external observers viewed the presentation several times making suggestions and comments prior to the decision that this portion of the practicum had been completed. Preliminary viewing evaluations have been extremely favorable. Several school systems and the Georgia Department of Education have requested the presentation for future utilization in teacher training.

4. Other Health Impaired Children Personnel Training Program

The personnel training program for the regular and special education teachers in the two pilot sites

was scheduled during the summer planning months and conducted during the school year. The plan proposed: 1) three group training sessions, and 2) a minimum of one individual contact per month, and 3) additional consultations on an individual basis.

The training program was developed and conducted by the participants. The group meetings were held during regularly scheduled staff meetings after the children had left the school and prior to the end of the school day.

The major items on the agenda of the first meeting that was held on 31 August 1977 in Bacon County and 14 September 1977 included:

a. An introduction of and explanation of the Other Health Impaired Children concept
b. A discussion of the definition of Other Health Impaired children
c. An explanation of the purpose of the project
d. A rationale for the effort
e. A discussion of the screening, diagnostic, evaluation and other programmatic procedures of the project

f. A distribution of the screening materials

g. A discussion of the expectations of the practicum staff, the individual teacher's role, and the responsibilities of each

h. An evaluation of the training session [9]

i. The administration of a pretest [10]

During the second sessions which were held on 18 January 1978 and 19 January 1978, the overall agenda provided an up-date of the progress of the project. It included:

a) A summary of the analysis of the screening data

b) A report of the number and types of handicapped children being served

c) A discussion of problems and/or achievements being faced

d) An overview of the procedures for the remainder of the practicum year

e) An evaluation of the training session

[9] The evaluation instrument is appended on pages 96.

[10] The evaluation instrument used as a pretest and posttest to measure effectiveness is appended on pages 97-98.

The third personnel training sessions were held on 1 June 1978 and 7 June 1978. The agenda consisted of:

a) A presentation of the slide/tape, "Medicine Is Not Always Enough"
b) A discussion of the handbook
c) A discussion of the results of the project
d) A summary of the proposed efforts for institutionalization
e) An administration of the posttest to measure effectiveness
f) An evaluation of the session

The evaluation instrument designed to be administered as a pretest and posttest was developed to evaluate the effectiveness of the training on the awareness of the trainees as to the basic concepts of the program. Data gathered on the first administration were used on planning the other group and individual sessions for personnel with specific problem areas such as epilepsy and asthma.

Individual conferences were scheduled with each of the teachers through the principal. Those who had children classified as Other Health Impaired in their classes received a minimum of one individual conference per

month. Many of these teachers received more than the minimum.

A classroom observation checklist to be used in evaluating the effectiveness of the training program in actual classroom application was developed.[11] This information was used in working with the individual teachers to reinforce or modify behavior.

Process

Implementing and monitoring the practicum was established in the following manner:

The participants and other project staff members such as the visiting teachers and hospital/homebound teachers met 26 August 1977 for an initial planning and orientation meeting. The objectives and procedures of the program were discussed.

The Other Health Impaired screening checklist

[11] A copy of the observation checklist is appended on page 99.

was reviewed. An agreement was reached as to the method of distributing and collecting the material. A schedule was set with a due date for the initial submission and collection of 1 October 1977.

The procedure of reviewing the school health records was also established and a timetable with a deadline of 15 October 1977 was determined. The type and extent of information to be gathered was pointed out. For example, if a particular child had had one of the identified physical conditions, parents were to be contacted to determine whether the condition was still active and whether there were educational evaluations that might need to be made.

The group also outlined the referral process to be followed. Each child considered for the Other Health Impaired program had to be assured procedural due process from the time of initial referral to the official placement by a legally constituted placement committee. Parental permission for evaluation and placement had to be obtained prior to the receipt of any special

services. Since each system has a Procedural Due Process Handbook with instructions and officially adopted forms for this process, the staff members reviewed the steps to be followed.

One of the major tasks of the practicum was to determine which children actually needed special education services. Theoretically, Other Health Impaired children have special educational needs as a result of their health problems. For this reason, some type of diagnostic evaluations had to be made. An outline of which diagnostic instruments to be employed was determined. The group decided to initially give each child a Slosson Intelligence Test, a Wide Range Achievement Test, and to use the Help Behavioral Observation Scale[12] for a record of on-task and off-task behavior in the classroom. If the child seemed to have severe learning and/or behavior problems, further evaluation (psychological, educational, and/or medical) would be implemented.

Monthly staff meetings were then scheduled to

[12]Mary Lee Armstrong, Project HELP. A copy is appended on pages 100-101.

monitor the progress of the project. Each participant and the other staff members were encouraged to make suggestions and discuss problem areas since the idea was to develop a viable model. The follow-up sessions were quite beneficial to the total effort of program modification and development.

Parental involvement in placement was initially established. Efforts were made to continue this component of the practicum with a minimum of monthly contacts for children who seemed to be having difficulties adjusting.

After the child was identified and the referral procedures had been completed, the child was placed in the program for Other Health Impaired children by a placement committee. This group wrote the Individual Education Plan. The implementation of the program for each child was monitored by the Other Health Impaired teacher.

The child's progress was also monitored closely. The teacher for the Other Health Impaired children observed the child periodically to

determine the effectiveness of the program. The degree of intervention by the special teacher was dependent on the needs of the child. Some children required close monitoring while others adjusted well without additional services. Children with illnesses that were in remission were simply placed in the program for observation or until services were needed.

During the Spring Quarter, all of the children enrolled in the program were given the Slosson Intelligence Test and the Wide Range Achievement Test in order to determine a measure of achievement.

The Other Health Impaired teacher also completed another Help Behavioral Observation Scale to obtain a measure of on-task and off-task classroom behavior. These data were used in the Annual Review of each child's placement and the development of the Individual Education Plan for the next school year.

Monthly reports of the number of children served by the program were submitted to the Georgia

Department of Education. Children placed on waiting lists for services were also reported. These children were included on the October 1 and February 1 Child Find forms that have been mandated by the Bureau of Education for the Handicapped.

At the end of the 1977-78 school year, the data were gathered and analyzed as a measure of evaluation. This information was used in planning and justifying institutionalization efforts for the 1978-79 school year. As a result of the practicum the program will be offered to Other Health Impaired children on a county-wide basis in each system at that time.

In the original proposal of this program, the participants intended to develop a policy and other recommendations concerning the services to Other Health Impaired children to be submitted to the local boards of education for adoption as board policy. However, when the Annual Program Plans were developed for total educational services to all handicapped children and were adopted by the boards, this procedure was not necessary.

Dissemination activities were conducted throughout the practicum. Radio spots were written and broadcast by the local radio stations in each county. Newspaper articles were placed in each of the local newspapers. The dissemination pamphlet was distributed to the Directors of Special Education in every system in the State of Georgia at the Spring Administrator's Workshop. The "Find and Help Other Health Impaired Children" brochure was also distributed to the superintendents of the school systems in the State at one of the quarterly Bootstrap Conferences. Approximately fourteen requests for additional information have been received. Other systems (N=6) have expressed an interest in the program and are awaiting the final report for possible implementation in their systems.

Information has been provided to the area Cooperative Educational Services Agency, the Georgia Learning Resources System, a resource network that covers the State, and the area teacher preparation colleges. Workshop presentations have been planned including an invitational seminar at the fall State conference for the members of the Council for Exceptional Children.

A copy of the practicum proposal was requested by the Public Information Office of the National Institute of Health. This office has also requested a copy of the final report in order to consider it for possible national dissemination.

Presentations to local civic organizations were made in each county. Some of these groups (N=15) included the Coffee County Association for Retarded Citizens, the Bacon County Rotary Club, and the Coffee County Council for Exceptional Children.

Dissemination activities in the area included presentations at Valdosta State College, the Waycross Junior Woman's Club and the Okefenokee Cooperative Educational Services Agency. A summary report was also given to the Evans County Research Project participants at the School of Public Health of the University of North Carolina at Chapel Hill.

Preliminary inquiries have been made to three educational publishers for possible submission

of the materials for publication. Copyright lawyers have been approached for assistance. This avenue would enable the program to have even further dissemination.

The final step in the practicum was to gather the information and evaluation data in order to write the practicum report. The report was submitted to the Coffee County and Bacon County Boards of Education in the July 1978 regular monthly meetings.

CHAPTER SEVEN

RESULTS

In order to evaluate the practicum, specific procedures designed to measure the objectives were presented in the original proposal. Each step was carefully followed to determine the effectiveness of the model.

Objective 1 was designed to make sure that the model program for providing services to Other Health Impaired children had actually been developed and implemented in the Coffee and Bacon County School Systems by 30 June 1978. The proposed criterion for mastery of this objective was the National Child Find Report (DE 856)[1] that must be submitted by the system superintendents semi-annually. An analysis of the February 1 reports submitted to the Georgia Department of Education by the two systems showed that at that time Coffee County was serving sixty-eight children and Bacon County was serving fifteen in this category. It can be concluded that the program had been established and that the objective had been met.

[1]Copies of the National Child Find Reports are filed in the local systems and with the Georgia Department of Education.

Objective 2 was concerned with the development, administration and evaluation of a screening procedure for Other Health Impaired children by 30 June 1978 as evidenced by the appropriate forms and procedures. The specific procedures and screening checklist that were discussed in Chapter Six were submitted to the internal and external observers prior to utilization. As a result of their comments and suggestions, five changes were made.

An informal rating scale was designed for the observers to use in evaluating the screening procedure.[2] A range of one to five was employed for the scoring. An overall rating of the product of 92% was received. Since the criterion of 80% for successful implementation had been established, this portion of the objective was reached.

Student records of children enrolled in special education programs in each system are on file in the offices of the Coordinators of Special Education. Records for eighty-three Other Health Impaired children were included. Because of the lack of definitive data, the participants had projected that five percent or sixty-one Other Health Impaired children would be located. Therefore, it can be

[2]A copy is appended on page 102.

surmised that the original estimate was too low. However, over sixty-one children were located and the objective was met.

The identification and placement of Other Health Impaired children by 30 June 1978 at Central Elementary School and Bacon County Junior High was Objective 3. This was to be evidenced first by the National Child Find Reports that do in fact support this accomplishment. Although it was projected that five percent of the student population would require this service, actually seven percent were located and placed. There was a discrepancy , however, between the elementary (grades 3-5) and the junior high (grades 6-8) in the number and percentage identified. Approximately nine percent of the elementary school children needed direct and/or related services for other health impairments while slighty more than two percent of the junior high pupils required this service. This seemed to indicate that possibly as the students mature some of the earlier health problems are corrected. Overall, this objective was met successfully.

Objective 4 dealt with the actual placement of Other Health Impaired children. The objective was to place

the children in the least restrictive environment according to due process procedures and have an Individual Education Plan written within thirty calendar days of placement. Ten folders were randomly selected from the files of the Coordinators of Special Education for analysis. All of the children in this group were placed in the regular classroom with their normal peer group. This constituted the least restrictive environment. The Individual Education Plan for each of these children supported that the placements were appropriate to the child's needs.

After a child is placed in a special education program in both Coffee and Bacon Counties, the special education teachers submit a Verification Sheet to the Coordinators of Special Education verifying that the child was assured procedural due process. This is accompanied by a Verification Checklist that documents the dates of each step in the process. In the random sample of records selected for this evaluation, each of the student's folders contained these forms.[3]

The third aspect of Objective 4 was that the Individual

[3]A copy of the Verification Sheet and Verification Checklist is appended on pages 103-104.

Education Plan had been written within the thirty calendar days after placement. In examining the records, there was an Individual Education Plan[4] that had been written at the placement committee meeting or at the time of placement for each child. Since both of the systems anticipated compliance monitoring by the Georgia Department of Education and the Bureau of Education for the Handicapped during the academic year, all of the special education teachers and school principals were careful to meet this requirement. This would account in part for the overall 100% success rating for this objective.

Objective 5 was concerned with the staff development activities of the classroom teachers who had Other Health Impaired children enrolled in their classes. Sixty-five teachers participated in the personnel training program. Agendas and rolls of the participants were kept and filed with the Coordinators of Special Education in each system.

The training sessions were evaluated by the use of an informal evaluation instrument.[5] Each group meeting

[4]Sample Individual Education Plans are found on pages 68-69.

[5]A copy of the evaluation instrument is found on page 96.

was rated. Scores of 95%, 91% and 92% for the value of the programs to the teacher in practical application were received on the three presentations. Verbal support by the professional staff was also quite positive.

The effectiveness of the training program was measured by the use of a test designed to be administered at the beginning of the practicum year and at the end of the year.[6] Information gathered from the first administration of the instrument during the fall was used to plan additional training activities. A 90% criterion for the success of the training program had been established.

Since the instrument was developed as a teaching tool, an item analysis of the test was not made. Overall, the questions that were missed most frequently were those that dealt with the subtle handicaps of illnesses such as the vision and auditory problems related to allergies and arthritis, and the teacher's role and responsibilities in making educational adaptations for Other Health Impaired children. The mean raw score for teachers from Coffee County was 15 or 60% on the pretest and 23 or 92% on the posttest. The mean raw score of teachers

[6]A copy of the instrument is appended on pages 97-98.

from Bacon County on the pretest was 18 or 72% and 24 or 96% on the posttest. Therefore, the criterion of 90% was reached.

The personnel training program also included individual conferences with teachers. A log was kept of each session with each teacher.[7] In addition to this log, an observational scale was designed and used to collect data on the extent to which the classroom teacher applied the knowledge presented in the training program.[8] This information was used in individual conferences.

The observational scale was first used in November of 1977. It was then administered in March and May of 1978. Table II provides a summary of the data gained from this instrument. It seemed to indicate that teachers have some difficulty in the application of ideas and concepts. It also seemed to suggest that continuous support and feedback are necessary until consistent assimilation is achieved. Although there were some problems with consistent application of knowledge mastered intellectually, there was measurable progress and the participants believe

[7]Sample logs are found on page 105.

[8]A copy of the observational scale is found on page 99.

TABLE II

OBERVATION OF TEACHER BEHAVIOR
AFTER TRAINING

N=65	Fall	Winter	Spring*
1. Checks health records	1 **2** 3 4 5	1 2 3 **4** 5	1 2 **3** 4 5
2. Refers suspected OHI students	1 **2** 3 4 5	1 2 3 4 **5**	1 2 3 **4** 5
3. Provides preferential seating when needed	1 **2** 3 4 5	1 2 3 4 **5**	1 2 3 **4** 5
4. Requests conferences with parents of OHI children	1 **2** 3 4 5	1 2 3 **4** 5	1 2 **3** 4 5
5. Adjusts amount of homework for the OHI child	**1** 2 3 4 5	1 2 **3** 4 5	1 **2** 3 4 5
6. Seeks information concerning disease of OHI child in room	1 **2** 3 4 5	1 2 3 4 **5**	1 2 3 **4** 5
7. Provides system for making-up work missed	1 **2** 3 4 5	1 2 3 **4** 5	1 2 **3** 4 5
8. Monitors medication schedules	1 **2** 3 4 5	1 2 3 **4** 5	1 2 3 **4** 5
9. Allows for special needs of child such as milk-break for ulcer	1 **2** 3 4 5	1 2 3 **4** 5	1 2 **3** 4 5
10. Uses "feed-back alerts" appropriately	**1** 2 3 4 5	1 2 3 **4** 5	1 2 **3** 4 5

*The ratings shown here represent the mean scores of the teachers observed during the project year.

that the objective was completed successfully.

Objective 6 dealt with parental involvement. The criterion for measuring the success of this objective was parental signatures on the Individual Education Plans. In the efforts to comply with the mandates of Public Law 94-142, parents and/or guardians have been involved in the placement of handicapped children and in the development of their Individualized programs. Therefore, at least one parent or guardian of each of the Other Health Impaired children placed during the project year was involved in the placement decisions and signed the appropriate forms prior to the initiation of any special services. A survey of the student records that were selected for analysis verified that this procedure had been followed 100% of the time.

Additional measures of parental involvement included the number of extensive individual conferences that were held concerning these children especially when the medical conditions were severe. The Other Health Impaired teachers made an average of one contact per month from the time of initial placement until the Annual Review. More than three hundred parent contacts were recorded including the placement and review meetings.

This effort with parents provided a very positive attitude for the Other Health Impaired Children's Program and for the special education program in the systems as a whole.

Objective 8 stated that 90% of the Other Health Impaired children would have been identified and placed and would be receiving the educational and related services mandated by their Individual Education Plans by 30 June 1978. This procedure was to be evidenced by student records, the Georgia Superintendent's Annual Report[9] and the Child Find Report. The reason for the 90% criterion was the fact that some of the related services needed by these children might not be available due to the limited funds and personnel.

An analysis of the randomly selected student folders revealed that all of the children were receiving the direct and/or related services that had been written into their Individual Education Plan. Whether the services were appropriate or the extent of their effectiveness was measured during the Annual Review.[10] According to the

[9]The Georgia Superintendent's Annual Reports are on file in each system. These reports verify the fact that the programs meet at least minimum standards established by the state and federal guidelines for such services.

[10]Sample copies of the Annual Review are appended on page 95.

data gained from these forms, the participants of the placement committee who wrote the reviews found that 91% of the long range goals, short term objectives, and related services needed by each child had been effective. Therefore, this objective was met.

Objective 8 was concerned with the actual academic achievement of students in the program for Other Health Impaired Children. The criterion for mastery was that the children would achieve as well as or better than they did before they were accepted into the program. Screening data were obtained prior to placement and posttests were administered at the end of the year. Tables III and IV are used to summarize the information from twenty randomly selected student folders. An average gain per month in school prior to the project year was computed. Then an average gain per month during the project year was obtained. The difference in the rate of gain prior to placement and after placement was determined. According to these data, 60% of the children had a higher learning rate after they were admitted to the program.

In analyzing the data, there were several considerations to make. First, the attendance of many of these students

TABLE III

PRE-TEST/POST-TEST COMPARISONS
FOR OHI STUDENT SAMPLE

Subject: Reading

N=20

Student	Grade	CA	MA	Pre-test	Gain in months	Post-test	Post gain in months	Difference in gains
A	4	8.6	7.4	3.0	8.0	4.2	12.0	+ 4.0
B	4	9.1	8.6	2.8	7.0	3.6	8.0	+ 1.0
C	5	10.2	10.6	4.7	9.0	5.1	4.0	- 5.0
D	4	9.6	9.2	3.5	9.0	4.5	10.0	+ 1.0
E	4	9.8	8.8	3.3	8.0	4.7	14.0	+ 6.0
F	3	9.5	8.6	2.0	7.0	2.9	9.0	+ 2.0
G	3	7.10	7.10	1.6	5.0	3.3	17.0	+12.0
H	3	8.10	10.0	3.8	13.0	4.8	10.0	- 3.0
I	4	8.11	12.2	7.6	19.0	9.0	14.0	- 5.0
J	3	8.9	7.4	2.5	8.0	4.2	17.0	+ 9.0
K	4	8.8	9.6	3.5	9.0	4.1	6.0	- 3.0
L	4	9.7	8.6	3.1	8.0	3.6	5.0	- 3.0
M	5	10.11	8.8	2.5	5.0	2.8	3.0	- 2.0
N	6	12.5	7.1	2.0	3.0	2.2	2.0	- 1.0
O	8	15.2	15.2	6.0	9.0	7.0	10.0	+ 1.0
P	7	14.0	11.3	5.0	7.0	5.7	7.0	+ - 0
Q	8	15.8	17.2	8.0	10.0	9.7	17.0	+ 7.0
R	7	14.2	9.0	3.0	4.0	3.8	8.0	+ 4.0
S	7	12.6	13.8	7.2	10.0	9.7	25.0	+15.0
T	8	13.3	15.5	6.5	8.0	9.3	28.0	+20.0

TABLE IV

PRE-TEST/POST-TEST COMPARISONS
FOR OHI STUDENT SAMPLE

BEST COPY AVAILAB

Subject: Math

N=20

Student	Grade	CA	MA	Pre-test	Gain in months	Post-test	Post gain in months	Difference in gains
A	4	8.6	7.4	3.6	9.0	4.2	6.0	- 3
B	4	9.1	8.6	2.7	2.9	3.2	5.0	+ 2.1
C	5	10.2	10.6	4.5	9.0	4.7	2.0	- 7
D	4	9.6	9.2	3.9	9.7	5.0	11.0	+ 1.3
E	4	9.8	8.8	3.6	9.0	4.2	6.0	- 3.0
F	3	9.5	8.6	2.2	7.3	3.2	10.0	+27.0
G	3	7.10	7.10	2.6	8.6	3.6	10.0	+ 1.4
H	3	8.10	10.0	2.8	9.3	2.8	10.0	+ 7.0
I	4	8.11	12.2	2.8	7.0	3.6	8.0	+ 1.0
J	3	8.9	7.4	2.4	8.0	3.0	6.0	- 2.0
K	4	8.8	9.6	3.2	8.0	3.6	4.0	- 4.0
L	4	9.7	8.6	3.9	9.7	4.7	8.0	- 1.7
M	5	10.11	8.8	3.0	6.0	3.0	-0-	- 6.0
N	6	12.5	7.1	2.1	3.5	2.3	2.0	- 1.5
O	8	15.2	15.2	5.4	6.7	6.8	14.0	+ 7.3
P	7	14.0	11.3	4.8	6.9	6.0	12.0	+ 5.1
Q	8	15.8	17.2	7.0	8.8	9.0	20.0	+11.2
R	7	14.2	9.0	2.4	3.4	4.0	16.0	+12.6
S	7	12.6	13.8	4.8	6.9	6.3	15.0	+ 8.1
T	8	13.3	15.5	6.0	7.5	8.7	27.0	+19.5

improved considerably after the program was initiated. One student had missed more than forty-five days during the previous year with epileptic seizures. With careful monitoring of his medication and frequent communication with his parents and physicians, the child was able to come to school 169 out of the 180 school days during the project year.

Other considerations included the fact that all of the children who were medically diagnosed as hyperkinetic were off-task 80% or more on the behavioral observation scale. After being placed on medication and after an adjustment period, this group was on-task an average of 78% or more of the time.

Some students did not do as well this year as they had in the past. This might have been due to the fact that their medical conditions had just been diagnosed or had recurred. However, it can be generally expected that the sick child would not be able to achieve as well under adverse conditions as he had when his health was good. Therefore, although not all of the children performed as well as or better than they had prior to the project year, the participants believe that the overall achievement

level was raised and the project was beneficial.

In order to evaluate the practicum process, an Evaluation Process Scale was utilized.[11] Each step in the procedures developed to carry out the practicum was listed and rated on a scale of 1 to 5. An 80% effectiveness score was set for successful implementation. When the self-rating scale was completed, a score of 92% was obtained.

The major problems that occurred dealt with the ability of the participants to establish feasible deadlines and turn-around times. Complications with the school schedules of the different systems were part of the reason, but the ability of the participants to anticipate and plan where time was concerned was weak.

Although mandates had been issued to institute a program for Other Health Impaired children, it is doubtful that the effort would have been as successful if it had not been for the practicum. The task that seemed so large to the participants became a matter of everyday procedure by the end of the school year.

[11] A copy is appended on pages 106-109.

CHAPTER EIGHT

DISCUSSION

As a result of this practicum, a model for the implementation of services to Other Health Impaired Children was developed, implemented and evaluated. The products and processes will be utilized to institutionalize the program in all of the schools in each system during the 1978-79 school year. It will also be disseminated to other systems in the area. New teachers and administrators will be trained with the Other Health Impaired Personnel Training Program and new students will be screened and placed.

A Handicapped Children's Model Program grant application has been submitted to the Bureau of Education for the Handicapped for funds to more thoroughly research this problem and make a more concerted effort to replicate the model. Favorable comments have been received from the Project Officer in Washington concerning Project MINE,[1] and the authors are hopeful that more extensive dissemination can be conducted.

[1]Mary Lee Armstrong and Wendell R. Tanner, Project MINE (Medicine Is Not Enough) (Douglas, Ga: Coffee County and Bacon County School Systems, 1978).

The cost of the practicum was quite minimal. The released time for the teachers/observers and for teacher training was provided at no extra cost to the system. Consultative services available through the Cooperative Educational Services Agency, the Georgia Learning Resources System, the Georgia Department of Education was provided free of charge. College personnel in the area colleges were also willing to review and make recommendations for materials without a fee. Dr. Leon E. Curry, the medical consultant, donated his time and expertise. The Special Education Programs in the two systems had sufficient funds for secretarial assistance to reproduce and assemble the materials. No special facilities were required. Including the purchase of graphic and printing services, the practicum cost less than three hundred dollars to conduct.

The development and implementation of this project did not require any additional labor demands on the system with the exception of the role change for the hospital/homebound teachers. These teachers were able to perform both roles without undue strain since their caseloads never reached the maximum. The effort did require more than 1200 man hours of the participants' time over a twelve month period.

This team was assembled to conduct the group practicum

because of the expertise and experience of each participant. Each member had job responsibilities that were needed to complete the different phases of development from the school to the system level. Appended is a table that provides a summary of the tasks assigned to individuals and the tasks that were to be completed by the group.[2]

The most crucial factors in conducting this practicum were time and reaching a consenus on decisions. The effort was a monumental task for busy administrators. It necessitated the coordination of resources, ideas and extensive information searches primarily because the medical and technical background of the participants was limited. The production of the handbook and the audio/visual materials was time consuming.

Hampered by the fact that the participants lived more than thirty miles apart, the simple decision concerning the location of work sessions was a problem. Each of the participants was a strong leader and wanted to lead in a different direction. Since this was detrimental to the achievement of the objectives, each learned to respect

[2]See appended on page 110.

the ideas of others and to work together to solve the problem. By the end of the practicum, the group had become a cohesive unit and worked together quite well. In fact, mastering the skill of working with other educational leaders to reach a solution to a common problem may be more benefical to the participants and to the local school systems in which they work than the program itself.

CHAPTER NINE

FURTHER APPLICATION

Since the problem of establishing and evaluating a model program for Other Health Impaired children has been faced or will be faced by most school systems, the response to this effort has been most positive. The Other Health Impaired Children Personnel Training Program, the Help Hints for the Management of Other Health Impaired Children, and "Medicine Is Not Always Enough" slide/tape presentation can be utilized to institutionalize the program within the systems and to replicate the program elsewhere.

Communications with publishers of educational materials have been favorable. It is hoped that the screening procedure, the handbook, and the audio/visual program can be packaged for production later. This would increase the dissemination significantly.

The project application submitted to the Bureau of Education for the Handicapped for funds for a Handicapped Children's Model Program would also further extend the

the model implementation. Formalized replication efforts would be initiated during the 1978-79 school year.

A copy of the final, approved report will be submitted to the Public Information Office of the National Institute of Health at the request of the agency. There is a possibility that this organization will assist with a dissemination effort.

CHAPTER TEN

CONCLUSION

As administrators and coordinators of special education, the participants were directly responsible for establishing programs to meet the needs of handicapped children and to comply with the mandates of the law. Employing educational perspective in program planning and organization provided the system with a model that can be shared around the area, the State and possibly the nation.

The participants understand that this project to develop a model program to provide services for Other Health Impaired children was an embyronic movement and will require many additional attempts along these lines by others prior to the establishment of the most effective and most appropriate program. Too long the doors of the medical profession have been closed to a working relationship with other than medical personnel. Too long the halls of education have remained filled with the sounds of reading, writing, and arithmetic for the child lingering there regardless of his physical condition.

However, this practicum has served to build a footbridge between the two, and this program can be used to further open the lines of communication.

Fulfilling the state and federal rules and regulations that accompany Public Law 94-142 does not necessarily mean that the education of the exceptional children in the schools of the nation will improve as is the intent of the legislation. This will require considerable study, planning, training, implementing strategies, evaluating and revising program models, and developing a continuous monitoring process at the local level. But a race is won by making the first step.

A P P E N D I X

CONFIDENTIAL

Name_____ Exact Birthdate_ _____

Sex_____Race_____Age_____ School_____

Address_____Telephone_____

Father's name_____Bus. phone_____

Mother's name_____Bus. phone_____

As part of the effort to serve all handicapped children, our school system is conducting a search for "Other Health Impaired" Children. These are children who have chronic or acute health problems which may affect the child's learning. We are planning to work with the teachers to find out whether these students need any special help while in their classroom. Your cooperation is needed. If your child has a chronic or acute health problem, please let us know. We will keep all information confidential.

If your doctor has diagnosed one of the following conditions as one from which your child is suffering, please check that condition:

	(X)
Heart condition	
Rheumatic fever	
Tuberculosis	
Hypertension	
Nephritis	
Asthma	
Sickle Cell anemia	
Hyperkinesis	

(X)	
	Hemophilia
	Epilepsy
	Lead Poisoning
	Diabetes
	Allergies
	Hypoglycemia
	Leukemia and other cancers
	Arthritis

Other health problems?_____

Family Doctor:_____ If your child is on medication, what kind, when is it to be taken, and how much?

_____

Find
AND
Help
Other
Health
Impaired
Children

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize

_____

_____
(Agency)

_____

to release all available educational, psychological, immunization, screening and_____
_____information on my child,_____
(other) (name)

_____.
(birthday)

to

_____

_____
(agency)

_____

I understand and agree to the above statement.

_____
Signature Date

(Authorization to be kept on file.)

(The above information is not to be released to a third party.)

Date_____

Doctor_____has seen my child and prescribed medication. The medication _____(name of drug) is to be taken at _____(time).

I hereby authorize the principal to allow my child_____to take the prescribed dosage at _____time while at school.

_____
Parents

RELEASE FORM
BACON COUNTY SCHOOLS
COFFEE COUNTY SCHOOLS

SERIES TITLE: "Medicine Is Not Enough"

I hereby authorize the use of my child, _____,
Child's Name
picture to be used in a slide/tape presentation for educational purposes. I understand that he/she will be used as a model for a program on Other Health Impaired children and how they are served in the school.

_____
NAME of PARENT or GUARDIAN

_____
RELATIONSHIP TO CHILD

_____
DATE

Anticipated Duration of Services: 1 yr

INDIVIDUALIZED EDUCATION PROGRAM: TOTAL SERVICE PLAN
INDIVIDUAL EDUCATION PLAN

STUDENT'S NAME Lee Tanner BIRTHDATE 2-20-65

SYSTEM Coffee County SCHOOL Coffee Junior High

DATE OF PROGRAM ENTRY 8-24-76 PROGRAM(S) OHI/LD

PARENT'S NAME Ray Tanner ADDRESS Rt. 1, Ambrose, GA PHONE 359-3030

COMMITTEE MEMBERS PRESENT:

	Student
	Parent
	LD Teacher
	OHI Teacher
	Principal

Annual/Long Term Goals	Person(s) to Provide Service	% of Time	Beginning Date	Review Date	Goals Achieved Yes	Goals Achieved No
1. To remediate arithmetic concepts and processes	LD teacher	1/6	9-1-77	5-31-78	X	
2. To monitor on-task behavior	OHI teacher	monthly	9-1-77	5-31-78	X	
3. To administer medication accroding to physician's schedule	Regular teacher	1 per day	9-1-77	5-31-78	X	
4. To keep physician informed of behavioral changes	OHI teacher	1 per qt	9-1-77	5-31-78	X	
5. To met with parents and keep informed	OHI teacher	1 per qt	9-1-77	5-31-78	X	

Present Levels of Educational Performance (Strengths & Weaknesses)	Testing Instruments Used: Name & Date Pre-test	Score	Name & Date Post-test	Score	Other Non-Academics (specify)
Reading Comprehension	WRAT 8-77	7.5	WRAT 5-78	8.2	
Mathematics Skills	WRAT 8-77	4.2	WRAT 5-78	7.7	
Verbal Communication adequate					
Written Communication adequate/ handwriting poor					
Social Development adequate on medication					
Sensory/Motor Development handwriting poor					
Spelling	WRAT 8-77	7.0	WRAT 5-78	8.1	
Other on mediccation	On task	85%	On task	83%	

I have reviewed this report and/or have been informed of its contents. YES X NO _____

Parent Signature _____ Date _____ Teacher Signature _____

INDIVIDUAL EDUCATION PROGRAM: SHORT TERM INSTRUCTIONAL OBJECTIVES
INDIVIDUAL EDUCATION PLAN

STUDENT'S NAME Lee Tanner AGE 12 SCHOOL Coffee Junior High TEACHER(S) Lewis - LD

PARENT'S NAME Ray Tanner PROGRAM OHI/LD Mitchell - OHI

ADDRESS Rt. 1, Ambrose, GA PHONE 359-3030 Harvey - Regular

Instructional Objectives	Behavior	Criteria for Mastery	Materials and/or Resources	Date Started	Evaluation and Date	Criteria Met	
						Yes	No
1. Lee will gain 12 mons. in arithmetic	CTBS/WRAT	85%	System 80	9-1-77	5-31-78	X	
2. Lee will be on-task 80% of the time	HELP Behavioral Observation Scale	80%	Medication	9-1-77	5-31-78	X	
3. Lee will recieve medication as perscribed by physician	Take pill	100%	Medication	9-1-77	5-31-78	X	
Complete short term objectives for arithmetic in LD file							

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I have reviewed this report and/or have been informed of its contents. YES X NO _____

Parent Signature _____ Date _____ Teacher Signature _____

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INDIVIDUALIZED EDUCATIONAL PROGRAM: ANNUAL REVIEW

Name of Student Lee Tanner Date of Birth 2-20-65 Age 13 Grade 7th School Coffee Junior High

Local Education Agency Name and Number Coffee County Schools 6431 Date of Annual Review 31 May 1978

IEP: Total Service Plan and Implementation/Instructional Components	Level of Appropriateness (Check appropriate space) YES	NO	Recommended Change:
Special Education Placement	X		
Regular Education Placement	X		regular 8th grade math program
Specific Special Education and/or Related Services	X		continue OHI; discontinue LD
Program Goal(s)	X		monitoring medicine; effective
Implementation/Instructional Short-term Objective(s)	X		met instructional and behavioral goals
Specific Materials and/or Resources	N/A		
Specific Teaching Strategies and/or Techniques	X		behavior modification; continue medical monitoring
Evaluation Criteria for Completion of Program Goal(s)	X		
Evaluation Criteria for Completion of Implementation/Instructional Objectives(s)	X		

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CHILD STUDY TEAM MEMBERS PRESENT

Signature	Position	Agreement of Annual Review (Check appropriate space) YES	NO
	Parent	X	
	Principal	X	
	LD Teacher	X	
	OHI Teacher	X	

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PERSONNEL TRAINING PROGRAM
PROGRAM FOR OTHER HEALTH IMPAIRED
WORKSHOP EVALUATION CHECKLIST

Please evaluate the training session. Your comments and suggestions will be used to revise the presentation. Thank you.

		Poor 1	2	3	4	good 5
1.	The presentation was informative	1	2	3	4	5
	Comment _____					
2.	Length of sessions was appropriate	1	2	3	4	5
	Comment _____					
3.	Audio/visual aids were timely	1	2	3	4	5
	Comment _____					
4.	Materials covered were helpful	1	2	3	4	5
	Comment _____					
5.	Handout materials were relavent	1	2	3	4	5
	Comment _____					
6.	This workshop is profitable for other teachers and administrators	1	2	3	4	5
	Comment _____					

General Comments:

_____

_____

_____

_____ Special Education Teacher _____ Administrator

_____ Regular Education Teacher _____ Other

Date: _____

OTHER HEALTH IMPAIRED TRAINING PROGRAM
PROGRAM EVALUATION

DATE: _____

Please mark the following items true or false. This information will be used to plan additional sessions and evaluate the other training sessions.

Thank you.

TRUE OR FALSE	STATEMENTS
_____	1. Blind children are included in the definition of Other Health Impaired(OHI)
_____	2. OHI children must be taught in self-contained classes for their own protection
_____	3. The medical conditions of OHI children are often contagious
_____	4. Lead poisoning retards mental ability
_____	5. Hyperkinesis is caused by emotional problems
_____	6. Diabetic children should have no sweets
_____	7. The regular class teacher should have no responsibility for OHI children
_____	8. A child who has a hearing problem probably has an allergy
_____	9. Rheumatoid arthritis can cause blindness
_____	10. After accidents and suicide, rheumatic fever is the leading cause of death among children
_____	11. The school lunchroom cannot be expected to make special provision for OHI children
_____	12. OHI children should not have physical education
_____	13. Hypertension means low blood sugar
_____	14. Give a diabetic child who is weak and dizzy a coke and peanut butter sandwich while waiting to transport to the doctor
_____	15. A child with an epileptic seizure should be restrained to keep him from hurting himself

_____ 16. Sickle cell anemia is always terminal

_____ 17. Epileptics are always retarded

_____ 18. Many gifted children are hyperkinetic

_____ 19. The law prohibits the dispensing of medicine at school

_____ 20. The school can play a big part in the medical management of OHI children

_____ 21. Information can be released to a child's physician without signed parental permission

_____ 22. A physician does not need to know how a child is doing in school

_____ 23. Teachers are often the most reliable observers of the medical treatment program that a doctor can find

_____ 24. Allowances in the classroom program can be made for OHI children

_____ 25. When an OHI child returns to school after an extended illness, he should be given extra work to help him catch up

OBSERVATIONAL CHECKLIST FOR TEACHERS
PROGRAM FOR OTHER HEALTH IMPAIRED
BACON/COFFEE COUNTY SCHOOL SYSTEMS

Teacher's name_____ Date_____
School_____ Grade_____

Following the training session(s) conducted by the staff of the program for Other Health Impaired students, the subsequent behavior changes have occurred either for the first time or in an increasing amount:

BEHAVIOR	OBSERVED Never 1	2	3	4	Often 5
1. Checks health records	1	2	3	4	5
2. Refers suspected OHI students	1	2	3	4	5
3. Provides preferential seating when needed	1	2	3	4	5
4. Requests conferences with parents of OHI children	1	2	3	4	5
5. Adjusts amount of homework for the OHI child	1	2	3	4	5
6. Seeks information concerning disease of OHI child in room	1	2	3	4	5
7. Provides system for making-up work missed	1	2	3	4	5
8. Monitors medication schedules	1	2	3	4	5
9. Allows for special needs of child such as milk-break for ulcer	1	2	3	4	5
10. Uses "feed-back alerts" appropriately	1	2	3	4	5

Observer_____ Observation no._____

Date_____ School System_____

CHILD _____ TEACHER _____ OBSERVER _____

SCHOOL _____ GRADE _____ HEALTH _____

DATE _____ TIME OF DAY _____ OBS/RECORD ____/____

ON MEDICATION? YES ____ NO ____

	ON TASK			OUT OF SEAT			WIGGLE			TALK			NOT ATTEND TEACH			OTHER		
	+	o	-	+	o	-	+	o	-	+	o	-	+	o	-	+	o	-
PAGE 1																		
PAGE 2																		
PAGE 3																		
SUM PAGE 1+2+3																		
SUM ÷ GRAND TOTAL																		

GRAND TOTAL

100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

1+2+3 4+5+6 7+8+9 10+11+12 13+14+15 16+17+18

SUM

(19) (20) (21) (22) (23) (24)

BEHAVIOR CATEGORIES

1	2	3	111 4+7+0+3+6	111 5+8+1+4+7	111 6+9+2+5+8	SUM
(25) + ON	(26) o ON	(27) - ON	(28) + OFF	(29) o OFF	(30) - OFF	

SUM	25+26+27	28+29+30
	ON	OFF

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ON TASK			OUT OF SEAT			WIGGLE			TALK			NOT ATTEND TEACH			OTHER			CONTENT
+	o	--	+	o	-	+	o	-	+	o	-	+	o	-	+	o	--	

PRODUCT EVALUATION RATING SCALE
PROGRAM FOR OTHER HEALTH IMPAIRED
BACON/COFFEE COUNTY SCHOOL SYSTEMS

Please evaluate the enclosed materials according to the following scale and make comments and suggestions where applicable. Your continued support to this effort is certainly appreciated. Thank you.

Mark each item on the basis of 1 to 5	Poor				Good
	1	2	3	4	5

1. The material is timely — 1 2 3 4 5

   Comments _____

2. As you interpret the law, the major points are covered — 1 2 3 4 5

   Comments _____

3. The presentation is clear — 1 2 3 4 5

   Comments _____

4. The presentation is attractive — 1 2 3 4 5

   Comments _____

5. The presentation can be understood by most lay people — 1 2 3 4 5

   Comments _____

6. The material is applicable to other systems — 1 2 3 4 5

   Comments _____

VERIFICATION - PROCEDURAL DUE PROCESS

I hereby verify that_____ has been placed in my
child's name
special education class according to due process procedures as evidenced by the
by the attached Verification-Procedural Due Process Form.

_____
teacher's name

_____
date

I hereby verify that_____ has been placed
child's name
in a special education class in my school according to due procedures as evidenced
by the attached Verification-Procedural Due Process Form.

_____
principal's name

_____
date

VERIFICATION - PROCEDURAL DUE PROCESS

NAME:_____ BIRTHDAY:_____

SCHOOL:_____

PROGRAM:_____

		DATE
1.	Parent Permission for Testing sent	
2.	Parent Permission for Testing received	
3.	Vision Screening Scheduled	
4.	Vision Screening Completed	
5.	Hearing Screening Scheduled	
6.	Hearing Screening Completed	
7.	Referral to Psychologist	
8.	Test Schedule	
9.	Parents Notified of Testing	
10.	Test Completed	
11.	Test returned to system	
12.	Parents Notified of time & place of Placement Committee	
13.	Placement Committee Notice Received	
14.	Placement Committee Met	
15.	IEP Developed	
16.	Parents Notified of Placement Committee Decision	
17.	Parent Form for Placement sent	
18.	Form Received	
19.	Student Placed	
20.	Verification Sheet sent to County Office	

OTHER HEALTH IMPAIRED: LOG

_____ Individual Conference _____Teacher

_____ School Mail/Feedback _____Principal

OBSERVER:_____ TRAINEE:_____

DATE:_____ CONTACT NUMBER:_____

_____

POINTS TO COVER: _____

_____

_____

_____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

FOLLOW-UP CONFERENCE SCHEDULED: _____

TRAINING COMPLETED:_____ _____
Observer Date

This is to certify that I have spent _____ hours in staff training for serving Other Health Impaired children and I feel that this training has been most benificial.

_____
Teacher's signature

EVALUATION SHEET - Process

PRACTICUMS LABORATORY
Group Proposal
Armstrong/Tanner/Williams

Procedure	Target Date	Completion	Effectiveness Adequate -- Inadequate	Comments
1. Secure approvals - Bacon	6-1-77	5-30-77	X 2 3 4 5	
Secure approvals - Coffee	6-1-77	5-30-77	X 2 3 4 5	
2. Secure permission - Bacon	6-1-77	5-30-77	X 2 3 4 5	
Secure permission - Coffee	6-1-77	5-30-77	X 2 3 4 5	
3. Contact health departments			1 2 3 4 5	
locals	7-1-77	7-1-77	X 2 3 4 5	
state	7-1-77	7-1-77	X 2 3 4 5	
federal	7-1-77	7-1-77	X 2 3 4 5	
4. Contact volunteer health agencies	7-1-77	7-1-77	X 2 3 4 5	all letters mailed
5. Secure literature searches			1 2 3 4 5	
ERIC	7-1-77	7-1-77	X 2 3 4 5	request mailed
Medicus Indicus	7-1-77	7-1-77	X 2 3 4 5	request mailed
6. Review literature, guidelines,			1 2 3 4 5	
and prepared materials	8-1-77	3-31-78	1 X 3 4 5	too massive; needed continuous review
7. Contact consultants - CESA	7-1-77	6-15-77	X 2 3 4 5	
GLRS	7-1-77	6-15-77	X 2 3 4 5	agreed to participate in dissemination
Valdosta State College	7-1-77	7-1-77	X 2 3 4 5	agreed in phone cpnversation
Developmental Analysis Center	7-1-77	6-1-77	X 2 3 4 5	agreed in first conference session

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EVALUATION SHEET - Process

PRACTICUMS LABORATORY
Group Proposal
Armstrong/Tanner/Williams

Procedure	Target Date	Completion	Effectiveness Adequate -- Inadequate	Comments
Pharmaceutical Laboratories	7-1-77	7-1-77	X 2 3 4 5	letters mailed
8. Visit National Institute of Health	7-29-77	7-29-77	X 2 3 4 5	very receptive
National Institute of Mental Health	7-29-77	7-29-77	X 2 3 4 5	very helpful
BEH	7-29-77	7-29-77	X 2 3 4 5	positive
9. Schedule teacher and staff training	7-15-77	7-15-77	X 2 3 4 5	
10. Develop training manual	8-1-77	4-1-78	1 X 3 4 5	timeline inappropriate; did not have enough knowledge at this point
11. Submit to observers	8-1-77	2-1-78	X 2 3 4 5	second submission
12. Revise and reproduce	8-30-77	4-1-78	X 2 3 4 5	
13. Develop transparencies	8-1-77	4-15-78	1 X 3 4 5	
14. Submit to observers	8-1-77	4-15-78	X 2 3 4 5	
15. Develop board policies	7-15-77	7-1-77	X 2 3 4 5	initial submission of APP mandated by Public Law 94-142
16. Submit to local boards of education	8-28-77	7-1-77	X 2 3 4 5	
17. Design screening procedure and forms	8-1-77	8-15-77	1 X 3 4 5	time and knowledge limited
18. Submit to observers	8-1-77	8-20-77	X 2 3 4 5	
19. Revise and reporduce screening pro-			1 2 3 4 5	
cedures and forms	8-30-77	9-15-77	X 2 3 4 5	
20. Write script (audio and visual)	8-15-77	5-1-78	X 2 3 4 5	needed time to master concept before making materials of this nature
21. Submit to observers	8-15-77	5-1-78	X 2 3 4 5	final approval

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EVALUATION SHEET - Process

PRACTICUMS LABORATORY
Group Proposal
Armstrong/Tanner/Williams

Procedure	Target Date	Completion	Effectiveness Adequate -- Inadequate	Comments
22. Revise and reproduce slide/tape	8-30-77	5-1-78	X 1 2 3 4 5	copies also readied for use
23. Submit to observers	8-30-77	5-15-78	X 1 2 3 4 5	FINAL APPROVAL
24. Revise - if necessary	9-10-77	-------	1 2 3 4 5	
25. Design dissemination pamphlet	8-15-77	8-15-77	X 1 2 3 4 5	
26. Submit to observers	8-15-77	8-15-77	X 1 2 3 4 5	
27. Revise and print (1,000)	8-30-77	8-30-77	X 1 2 3 4 5	had 2,000 printed
28. Schedule and conduct staff training	8-31-77	8-25-77	X 1 2 3 4 5	
29. Conduct teacher training - group 1	9-8-77	10-1-77	1 X 2 3 4 5	off schedule; completed here
group 2	1-8-78	2-1-78	X 1 2 3 4 5	
group 3	5-15-78	5-31-78	X 1 2 3 4 5	fine except for schedule
Conduct teacher conferences 1	9-15-77	10-1-77	X 1 2 3 4 5	for all OHI identified
2	10-15-77	10-31-77	X 1 2 3 4 5	
3	11-15-77	11-30-77	X 1 2 3 4 5	
4	12-15-77	12-2077	X 1 2 3 4 5	
5	2-15-78	2-1-78	X 1 2 3 4 5	
6	3-15-78	3-1-78	X 1 2 3 4 5	
7	4-15-78	4-1-78	X 1 2 3 4 5	
30. Initiate screening procedures	9-15-77	9-15-77	X 1 2 3 4 5	

EVALUATION SHEET - Process

PRACTICUMS LABORATORY
Group Proposal
Armstrong/Tanner/Williams

Procedure	Target Date	Completion	Effectiveness Adequate -- Inadequate	Comments
31. Follow due process	9-77/6-78	9/77-6-78	X 2 3 4 5	very important
32. Establish program	10-1-77	9-15-77	X 2 3 4 5	
33. Evaluate for program modification	10-31-77	10-31-77	X 2 3 4 5	
	2-28-78	2-28-78	X 2 3 4 5	
	5-31-78	5-31-78	X 2 3 4 5	
34. Conduct annual follow-up sessions	5-31-78	5-31-78	X 2 3 4 5	all children completed by this date
35. Complete forms - state and federal	10-1-77	10-1-77	X 2 3 4 5	
	12-15-77	12-15-77	X 2 3 4 5	
	2-1-78	2-1-78	X 2 3 4 5	83 OHI reported
	3-1-78	3-1-78	X 2 3 4 5	
	6-15-78	6-15-78	X 2 3 4 5	
36. Gather and anaylze data	6-15-78	6-15-78	X 2 3 4 5	
37. Dissemination	11/77-6/78	9/77-6/78	X 2 3 4 5	a strength of the project
38. Present to local boards of education	7-15-78	7/77-7/78	1 2 3 4 5	with Annual Program Plan
39. Write Practicum Report	7-31-78	7-15-78	X 2 3 4 5	YEAH! We did something on time!
40. Submit to publishers	8-31-78	6-30-78	X 2 3 4 5	initial contact made
			1 2 3 4 5	
			1 2 3 4 5	

ROLE [illegible]AGRAM FOR PARTICIPANTS DESIGNING AND IMPLEMENT[illegible] MODEL FOR SERVING OTHER HEALTH IMPAIRED CHILDREN

CODE: (PR) = Primary Responsibility (SR) = Shared Responsibility (SuR) = Supportive Resp. (LR) = Little or No Resp.

Evaluation, Coffee County (PR)	Evaluation, Bacon County (PR)	Evaluation, Overall (PR)
Commercial Package Design (SR)	(SR)	(SR)
Ed-Med Decisions (medications, etc.(PR)	(LR)	(LR)
(LR)	(LR)	Required Inputs (Coord., Budget (PR)
Monitoring (Mechanics) (PR)	Monitoring (Outputs) (PR)	Monitoring (Comparative) (PR)
Due Process Procedure (SR)	Due Process Procedure (SR)	Due Process Procedure (SR)
(SuR)	InService Education (PR)	(SuR)
(SuR)	(SuR)	Media Production (PR)
Model Control (SR)	Model Control (SR)	Model Control (SR)
Basic Model Design (PR)	(SuR)	(SuR)
Medical Facility & Assoc. Visitat. (SR)	Med. Fac. & Assoc. Visitat. (SR)	Med. Fac. & Assoc. Visita. (SR)
Review of Literature & Research (SR)	Review of Literature & Res. (SR)	Review of Literature & Res. (SR)
SuR	Primary Background Data (PR)	SuR

MARY ARMSTRONG, Special Education Coordinator, Coffee County Schools
BACKGROUND: Special Education Teacher, Coordinator of Project HELP (Hyperkinesis and Educational Learning Problem), Coordinator of Special Education, Research Coordinator of Developmental Analysis Center, Participant of Evans County Projects (Hypertension Research, University of North Carolina)

WENDELL TANNER, Principal, Bacon Junior High and Coordinator of Special Education, Bacon County Schools
BACKGROUND: Counselor, Curriculum Director for Coffee County, Principal - Clinch, Coffee, and Bacon Counties, Coordinator of Special Education - Coffee and Bacon Counties, Director of Early Childhood Education

JULIAN WILLIAMS, Assistant Superintendent, Coffee County Schools
BACKGROUND: Naval Journalist, Biology and Social Studies Teacher, Counselor, Principal-Eastside-Westside and Central Schools, Coffee County, Director, Tutorial Program for Children with Learning Problems, Assistant Superintendent of Coffee County Schools

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